Commonwealth of Virginia
Department of Medical Assistance Services

2007 Focused Study Report: Children and Adolescents' Access to Primary Care Practitioners

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Executive Summary

The Michigan Peer Review Organization (MPRO) conducted this focused study for the Commonwealth of Virginia, Department of Medical Assistance Services (DMAS) to assess children and adolescent's access to primary care practitioners. Results of the review of care provided to Family Access to Medical Insurance Security (FAMIS) enrollees in contracted managed care organizations (MCOs), Primary Care Case Management (PCCM), and the State's fee-for-service (FFS) delivery system are provided in this report.

Specifications

Rates for enrollee access to care were established using the Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications for the measure *Children and Adolescents' Access to Primary Care Practitioners*. The rate represents the percentage of children 12 – 24 months and 25 months – 6 years of age who saw a health care provider for primary care at least once in the preceding year. For children 7 – 11 and 12 – 19 years of age, the measure represents the percentage that saw a provider for primary care at least once within the last two years.

Topic Description

Access to health care, defined by the Institute of Medicine as "the timely use of personal health services to achieve the best possible outcomes", is a fundamental problem for children in the United States.[1] In particular, children in low-income families face social and health care challenges that can lead to earlier death, chronic illness, pregnancy, drug addiction, or sexually transmitted diseases. Because of these risks, children must have adequate access to care.

Results

As shown in Table A, access rates ranged from 76.8% for enrollees aged 12 – 19 years to a high of 90.8% for enrollees aged 12 – 24 months.

Table A. Children and Adolescents' Access to PCPs – 2007

Age Range	2007	HEDIS® 2008 National Medicaid Average
12 – 24 months*	90.8%	94.1%
25 months – 6 years*	80.1%	84.9%
7 – 11 years	79.6%	86.0%
12 – 19 years	76.8%	83.2%

**Rates are for FAMIS enrollees only for ages 12 months – 6 years. SCHIP Medicaid Expansion is limited to enrollees aged 6 – 18 years.*

The 2007 rates for access to care declined by 5 to 10 percentage points from rates for 2004 – 2006. Rates for all age groups for 2007 were less than the HEDIS® national Medicaid average. Evaluation of enrollee access to primary care physicians (PCPs) by program showed declines from 2005 to 2007 for all age groups, with the highest increases in FAMIS and SCHIP Medicaid Expansion for children aged 7 – 11 years and 12 – 19 years. The largest decreases were seen in the older age groups for FFS. Enrollee access to PCPs by program also showed decreases from 2005 to 2006; the relative magnitude of decreases did not vary substantially by program, although decreases were greater as age increased.

[1] Randolph, Greg; Murray, Mark; Swanson, Jill; Margolis, Peter. "Behind Schedule: Improving Access to Care for Children One Practice at a Time". Pediatrics Vol. 113. No. 3 March 2004.

Summary

This study quantified, by age group, children and adolescents' rate of preventive care visits with primary care doctors. Overall, access rates declined for all four age groups from 2006 to 2007. Rates for each of the four age groups were also below the HEDIS® 2008 national Medicaid average. Examination of the rates by delivery system showed FFS enrollees had the largest decreases from 2006 to 2007. Reviewing results by SCHIP population showed similar decreases in the FAMIS and SCHIP Medicaid expansion program groups from 2006 to 2007. MPRO recommends additional study to assess if there are any patterns, anomalies, or known policy changes, etc. that may be driving the apparent decrease in access rates across all age groups and programs.

Chapter 1 – Focused Study Overview

Introduction

The Commonwealth of Virginia, Department of Medical Assistance Services (DMAS) is responsible for the provision of healthcare to the thousands of children enrolled in Medicaid in the Commonwealth of Virginia. Approximately 36% of children aged 15 months – 20 years in the state Medicaid program are enrolled in one of five managed care organizations (MCOs) who contract with physicians to provide timely, appropriate well-child care to these enrollees. DMAS contracted with the Michigan Peer Review Organization (MPRO) to conduct focused studies of care provided to the Medicaid managed care enrollees in five managed care organizations. The focused studies also reviewed care provided to enrollees in the fee-for-service (FFS) and Primary Care Case Management (PCCM) delivery systems. The majority of Medicaid enrollees (58%) aged 0 – 20 years are in FFS and the remaining 6% are in PCCM. DMAS selected five topics for focused studies: Well-Child and Adolescent Well Care, Immunizations; Access to Primary Care Practitioners (PCPs); Use of Appropriate Medications for People with Persistent Asthma; and Prenatal Care.

This report provides results for Access to Primary Care Practitioners. MPRO used Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications as the basis for selection and analysis.[1] Data analysis was performed using the SAS™ System for Windows. Study results are reported by program (population) and delivery system.

Programs (Population)

Virginia's State Children's Health Insurance Program (SCHIP), is called the Family Access to Medical Insurance Security (FAMIS), and is authorized under Title XXI of the Social Security Act for low-income people. FAMIS is financed by Federal (65%) and State (35%) funds and administered by DMAS in accordance with Federal and State guidelines. DMAS created FAMIS in 2001 to provide health insurance coverage to low income children whose families' incomes are too high to qualify for Medicaid. FAMIS covers eligible children (who are not eligible for Medicaid, are not covered under health insurance, and are not members of a family eligible for coverage under the State employee health plan). FAMIS provides coverage to children up to age 19 in households with incomes ranging from 133% to 200% of the federal poverty level (FPL). Enrollee eligibility aid categories 006, 007, 008, and 009 are included in the FAMIS program.

Virginia operates a combination SCHIP program that includes a Medicaid Expansion component that is funded under Title XXI. The Medicaid Expansion program covers children ages 6 through 19 in households with incomes ranging from 100% to 133% of FPL (children younger than six years of age within this FPL range are covered by Medicaid). For this study, SCHIP Medicaid Expansion is defined as enrollees in eligibility aid category 094.

[1] National Committee for Quality Assurance (NCQA), HEDIS 2008: Vol. 2: Technical Specifications. Washington, DC: NCQA; 2007.

Delivery Systems

The focused study reviewed care provided to enrollees in both FAMIS and SCHIP Medicaid Expansion programs. The focused study used three delivery system classifications to report findings:

1. Fee For Service (FFS) – primary care providers are paid directly by DMAS on a FFS basis
2. Primary Care Case Management (PCCM) Program (MEDALLION) – managed care
3. Managed Care Organization – recipients are enrolled in one of five MCOs (Medallion II) – managed care

Methodology

This study assesses how regularly enrollees access preventive care services by measuring visit rates to a PCP within a set period for specific age groups. MPRO calculated rates for enrollee access to care using the 2008 HEDIS® technical specifications for *Children and Adolescents' Access to Primary Care Practitioners*. The rate represents the percentage of children 12 – 24 months and 25 months – 6 years of age who saw a health care provider for primary care in the preceding year. For children 7 – 11 and 12 – 19 years of age, the measures represent the percentage that saw a provider for primary care within the last two years. For purposes of this study, any of the following specialty types were classified as primary care: obstetrics and gynecology, family, and nurse practitioners; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) specialist, school based clinic, quality health center, family practice, general practice, internal medicine, neonatology/pediatrics, and preventive medicine.

Selection parameters used to define the population included in the focused study are shown in Table 1 below.

Table 1. Selection Parameters for Access Focused Study

Program Types	FAMIS (Enrollee Eligibility Aid Category = 006, 007, 008, 009) SCHIP Medicaid Expansion (Enrollee Eligibility Aid Category = 094)
Delivery Systems	FFS (Benefit Definition Plan Subprogram Code = 01) PCCM (MEDALLION) (Benefit Definition Plan Subprogram Code = 02, 07) MCO (Medallion II) (Benefit Definition Plan Subprogram Code = 03, 04)
Enrollment Criteria	Minimum of 12 months continuous enrollment within the same delivery system and program during 2006 for age stratifications 12 – 24 months and 25 months – 6 years. Minimum of 24 months continuous enrollment within the same delivery system and program during CYs 2006 and 2007 for age stratifications 7 – 11 and 12 – 19 years
Diagnosis	None
Age	12 – 24 months, 25 months – 6 years, 7 – 11 years, 12 – 19 years
Sex	Male, Female
Office Visit Requirement	Not applicable
Review Period	12 months – 6 years: 1/1/2007 – 12/31/2007 7 – 19 years: 1/1/2006 – 12/31/2007

Reporting Results

The National Committee for Quality Assurance (NCQA) publishes Quality Compass® using audited HEDIS® results from health organizations. Quality Compass® allows users to conduct competitor analysis, examine quality improvement, and benchmark plan performance. Benchmarks used in this report are from 2008 Quality Compass® for the Medicaid population for 2007 dates of service.[2] Non-statistical comparison is made to the national Medicaid HEDIS® mean (average) for 2008, which is based on 2007 service dates, referred to in the report as the "HEDIS® 2008 national Medicaid average".

This report compares 2007 rates to rates from prior year studies. Rates for 2005, 2006, and 2007 are based on a calendar year. The sources for prior year information are:

- Information for 2004 is from the Commonwealth of Virginia Clinical Study – FAMIS for 2004.
- Information for 2005 is from MPRO's FAMIS Focused Study Report – Calendar Year 2005, published in April 2007.
- Information for 2006 is from MPRO's Focused Quality Studies Report – Calendar Year 2006, published in June 2008.

[2] The source for data contained in this publication is Quality Compass® 2008 and is used with the permission of the NCQA. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

Chapter 2 – Focused Study Results

Introduction

Access to health care, defined by the Institute of Medicine as "the timely use of personal health services to achieve the best possible outcomes", is a fundamental problem for children in the United States.[4] In particular, children in low-income families face social and health care challenges that can lead to earlier death, chronic illness, pregnancy, drug addiction, or sexually transmitted diseases. Because of these risks, children must have adequate access to care.

The primary goals of Healthy Virginians 2010 are increasing the quality and years of healthy life, and eliminating health disparities. Access to care is a critical component of a quality health care delivery system. For progress toward these goals to be realized, it is imperative that there be adequate access to a comprehensive health care system. Such a system must underscore the importance of prevention and be able to provide high-quality care in a culturally and linguistically sensitive manner.[5]

Focused Study Results

Indicator # 1

The percentage of children and adolescents with access to primary care services.

The 2007 rates for access to care declined by 5 to 10 percentage points from rates for 2004 – 2006. Rates for all age groups for 2007 were less than the HEDIS® national Medicaid rates as shown in Table 2. Rates ranged from 76.8% for enrollees aged 12 – 19 years to a high of 90.8% for enrollees aged 12 – 24 months.

Table 2. Children and Adolescents' Access to PCPs Comparison by Age (FAMIS + SCHIP Medicaid Expansion)

Age Range	Rate				HEDIS® 2008 National Medicaid Average
	2004	2005	2006	2007	
12 – 24 months*	95.1% (N=529)	95.3% (N=640)	95.9% (N=727)	90.8% (N=29,676)	94.1%
25 months – 6 years*	86.1% (N=4,274)	87.0% (N=4,142)	89.1% (N=4,787)	80.1% (N=104,162)	84.9%
7 – 11 years	86.5% (N=5,678)	83.2% (N=2,666)	90.6% (N=2,902)	79.6% (N=56,163)	86.0%
12 – 19 years	83.3% (N=5,923)	80.4% (N=4,862)	87.1% (N=4,981)	76.8% (N=69,746)	83.2%

**Rates are for FAMIS enrollees only for ages 12 months – 6 years. SCHIP Medicaid Expansion is limited to enrollees aged 6 – 18 years.*

Evaluation of enrollee access to PCPs by program shows declines from 2005 to 2007 for all age groups, with the highest increases in FAMIS and SCHIP Medicaid Expansion for children aged

[4] Randolph, Greg; Murray, Mark; Swanson, Jill; Margolis, Peter. "Behind Schedule: Improving Access to Care for Children One Practice at a Time". Pediatrics Vol 113. No. 3 March 2004.

[5] Healthy Virginians 2010 Objectives. Virginia Department of Health.

7 – 11 years and 12 – 19 years as shown in Table 3. The largest decreases were seen in the older age ranges for FFS. For all delivery systems, declines increased as age increased.

Table 3. Children and Adolescents' Access to PCPs Comparison by Delivery System (FFS and MCO)

Age Range	FFS			MCO		
	2005	2006	2007	2005	2006	2007
12 – 24 months	**97.8%**	**96.28%**	**88.9%**	**93.3%**	**95.68%**	**93.1%**
Num / Den	273 / 279	207 / 215	12,006 / 13,507	333 / 357	487 / 509	14,064 / 15,105
25 months – 6 yrs	**89.9%**	**90.50%**	**75.4%**	**83.6%**	**88.31%**	**82.5%**
Num / Den	1,909 / 2,124	1,362 / 1,505	23,202 / 30,759	1,639 / 1,961	2817 / 3,190	55,889 / 67,772
7 – 11 yrs	**88.4%**	**91.64%**	**74.5%**	**77.9%**	**89.53%**	**82.2%**
Num / Den	1,110 / 1,255	833 / 909	10,778 / 14,463	1,027 / 1,318	1,599 / 1,786	30475 / 37,094
12 – 19 yrs	**86.3%**	**88.06%**	**74.7%**	**75.1%**	**85.80%**	**78.6%**
Num / Den	1,771 / 2,051	1,239 / 1,407	16,000 / 21,406	1,913 / 2,547	2,718 / 3,168	33,376 / 42,482

Table 3. Children and Adolescents' Access to PCPs Comparison by Delivery System (continued) (PCCM and Combined Rate)

Age Range	PCCM			Combined Rate		
	2005	2006	2007	2005	2006	2007
12 – 24 months	**100.0%**	**100.0%**	**83.3%**	**95.3%**	**95.87%**	**90.8%**
Num / Den	4 / 4*	3 / 3*	886 / 1,064	610 / 640	697 / 727	26,956 / 29,676
25 months – 6 yrs	**94.7%**	**92.39%**	**76.6%**	**87.0%**	**89.07%**	**80.1%**
Num / Den	54 / 57	85 / 92	4,315 / 5,631	3,602 / 4,142	4,264 / 47,87	83,406 / 10,4162
7 – 11 yrs	**88.2%**	**94.69%**	**75.0%**	**83.2%**	**90.56%**	**79.6%**
Num / Den	82 / 93	196 / 207	3,454 / 4,606	2,219 / 2,666	2,628 / 29,02	44,707 / 56,163
12 – 19 yrs	**84.8%**	**93.35%**	**71.1%**	**80.4%**	**87.05%**	**76.8%**
Num / Den	224/264	379 / 406	4,164 / 5,858	3,908 / 4,862	4,336 / 4,981	53,540 / 69,746

**The population for PCCM enrollees aged 12 -24 months for 2005 - 2006 is too small to draw conclusions.*

Evaluation of enrollee access to PCPs by focused study population also showed decreases from 2006 to 2007. The relative magnitude of decreases did not vary substantially by program. Decreases were greater as age increased. Table 4 shows rates for 2004 through 2007.

Table 4. Children and Adolescents' Access to PCPs by Program

Age Range	FAMIS				SCHIP Medicaid Expansion			
	2004	2005	2006	2007	2004	2005	2006	2007
12 – 24 months	95.1%	95.3%	95.9%	91.1%	NA	NA	NA	NA
25 months – 6 years	86.1%	87.1%	89.2%	82.0%	89.3%	81.3%	81.4%	67.5%
7 – 11 years	85.4%	82.3%	90.0%	84.5%	88.6%	85.6%	91.3%	84.2%
12 – 19 years	82.2%	79.0%	89.1%	80.0%	86.1%	83.4%	87.8%	79.3%

Note: SCHIP Medicaid Expansion is limited to enrollees aged 6 – 18 years.

Summary and Conclusions

This study quantified, by age group, children and adolescents' rate of preventive care visits with primary care doctors. Overall, access rates declined for all four age groups from 2006 to 2007. Rates for each of the four age groups were also below the HEDIS® 2008 national Medicaid average. Examination of the rates by delivery system showed FFS enrollees had the largest decreases from 2006 to 2007. Reviewing results by population showed similar decreases in the FAMIS and SCHIP Medicaid expansion program groups from 2006 to 2007.

Opportunities for Improvement

Although parents have a responsibility to take care of their children, below-average results indicate room for improvement. DMAS can collaborate with MCOs to take a more active role in educating parents about the importance of routine care, in developmental examinations and in reaching out to enrollees to remind them when such care is needed. Managed care organizations are often set up to provide such outreach for various purposes already and DMAS may wish to consider a similar effort for its enrollees in the FFS and PCCM delivery systems. DMAS may also wish to consider requiring an additional study indicator within the required Well-Child Performance Improvement Project from the MCOs to address the declines in access rates. Interventions might focus on reminders to physicians and/or patients. MPRO recommends additional study to assess if there are any patterns, anomalies, or known policy changes, etc. that may be driving the apparent decrease in access rates across all age groups and programs. One source of additional data are the Member Satisfaction composites from the Consumer Assessment of Healthcare Providers and Systems (CAHPS® 4.0H) related to *Getting Needed Care* and *Getting Care Quickly*, this additional data will help to determine how broad the issue is.

The interpretation of this measure is straightforward – lower rates suggest a problem with access: children cannot access care, or parents do not understand the importance of routine care and therefore do not seek it. In either case, changes such as increased provider networks or setting standards for office hours that make care more accessible to members can have a measurable impact. DMAS can help to facilitate such changes by either modifying contracts or enforcing existing contractual requirements that support these efforts.

Appendix A – HEDIS® Specification Code Table

Codes to Identify Ambulatory or Preventive Care Visits		
Description	**CPT Codes**	**ICD-9-CM Codes**
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	
Home services	99341-99350	
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412,99420, 99429	
General medical examination		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9